Ohio Reproductive Medicine

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Authorization for Release of Medical Information

To:_____

_____

Date of Request:_____ Patient #: _____ Date of Birth:_____

Patient Name:_____ SSN: _____

Address: _____

_____

I hereby authorize the release of the following from my medical records:

- ☐ HSG Films/Disk
- ☐ Lab Results
- ☐ Medication List
- ☐ Operative Notes
- ☐ Pathology Report
- ☐ Semen analysis

Submit to:
Ohio Reproductive Medicine
4830 Knightsbridge Blvd., Ste. E
Columbus, Ohio 43214
Phone: 614-451-2280
Fax: 614-451-4352

Please forward before my appointment on: _____

This authorization is valid for 90 days from the date of signature.

It may be revoked in writing by the undersigned at any time prior to the release of the information from the disclosing party.

The requester may not lawfully further use or disclose the health information unless another authorization is obtained, unless disclosure is specifically required or permitted by law.

The patient may inspect or copy the protected health information used or disclosed pursuant to authorization and may refuse to sign this authorization. The patient shall receive a copy of this authorization upon request.

Patient's Signature Date